DISASTER MEDICAL/HEALTH PREPAREDNESS PLAN

developed by the:

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I. INTRODUCTION

1.0 STATEMENT OF PURPOSE

This plan is designed to assist medical and health personnel throughout the County of Marin to plan for, respond to, and recover from a disaster. It is an adjunct to the Marin County Operational Area Emergency Plan and consistent with Regional and State medical/health plans and documents.

2.0 MISSION STATEMENT

The mission of the Medical/Health Branch is to:

1) Maximize the continued operations of the emergency medical response system (EMS) to best meet routine EMS needs and extraordinary needs generated by the disaster.

2) Support the functions ("operationalize" the functions) of the Medical/Health Branch Director(s) as detailed in the Marin County Operational Area Emergency Plan.

3) Liaison with the Regional Disaster Medical/Health Coordinator (RDMHC) as directed in the Region II Disaster Medical/Health Emergency Plan.

3.0 PHILOSOPHY

The Disaster Medical/Health Preparedness Plan is consistent with the philosophy of the Marin County Department of Health and Human Services and strives to promote physical and mental health and prevent disease, injury, and disability.

4.0 AUTHORITIES

1) **California Health and Safety Code, Division 2.5 (Sections 1797-1799), "Emergency Medical Services", 1980, Update effective Jan. 1, 1996**

Known as the EMS System and the Pre-hospital Emergency Medical Care Personnel Act, its intent is to provide a statewide system for emergency medical services by establishing, within the Health and Welfare Agency, the Emergency Medical Services

Authority (EMSA), which is responsible for the coordination and integration of all state activities concerning emergency medical services.

2) **California Health and Safety Code, Sections 101040 and 101475.**

Section 101040. The county health officer may take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency", "state of emergency", or "local emergency", as defined by Section 8558 of the Government Code, within his or her jurisdiction.

"Preventive measure" means abatement, correction, removal or any other protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health.

The county health officer, upon consent of the county board of supervisors or a city governing body, may certify any public health hazard resulting from any disaster condition if certification is required for any federal or state disaster relief program.

Section 101475. The city health officer may take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency", "state of emergency", or "local emergency", as defined by Section 8558 of the Government Code, within his or her jurisdiction.

3) **California Health and Safety Code, Division 2.5, Section 1797.152, Regional Disaster Medical and Health Coordinator; Appointment, 1989**

This code stipulates that the Regional Disaster Medical and Health Coordinator (RDMHC) shall be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency chosen by majority vote of the local health officers in a mutual aid region. This section authorizes the RDMHC to coordinate the acquisition of mutual aid resources from the jurisdictions in the region, and to develop region-wide mutual aid plans.

4) **California Code of Regulations, Title 19, Division 2, Chapter 1; the Standardized Emergency Management System (SEMS)**

These regulations establish the SEMS based upon Incident Command System (ICS) and multi-agency coordination (MACS) as developed by the Fire fighting Resources of California Organized for Potential Emergencies (FIRESCOPE), the operational area concept, and the Master Mutual Aid Agreement and related mutual aid systems

including the five levels of response (field response, local government, operational, regional and state); an advisory board; training; and compliance.

5) **California Government Code, Section 8607; Standardized Emergency Management System (SEMS)**

SEMS is intended to standardize response to emergencies involving multiple jurisdictions or multiple agencies: provides for a course of instruction, implementation, coordination of multiple jurisdiction or agency operations, and after action reports.

6) **California Code of Regulations, Title 22, Division 9, Chapters 1-8**

These regulations include the following:

Chapter 1	The EMSA and the Commission on Emergency Medical Services – Conflict of Interest Code
Chapter 1.2	First Aid Testing for School Bus Drivers
Chapter 2	Emergency Medical Technician I
Chapter 3	Emergency Medical Technician II
Chapter 4	Emergency Medical Technician-P
Chapter 7	Trauma Care Systems
Chapter 8	Pre-hospital EMS Aircraft Regulations

7) **State of California Emergency Plan, Annex D "Emergency Medical Services", State OES, May 1988**

Annex D presents general concepts and policies to be followed in providing disaster medical services during each operational phase of a natural or technological emergency. It describes California's disaster medical care system and assigns state agency responsibilities.

8) **Disaster Medical Response Plan, Emergency Medical Services Authority, July 1992**

Describes the policies and general procedures governing the Emergency Medical Services Authority's (EMSA) response to major disasters involving mass casualties. To provide context, the plan details the roles and responsibilities of local, state, and private agencies and organizations, and describes the structure, concepts, and policies under which the response operates.

9) **Region II, Regional Disaster Medical/Health Coordinator, Interim Emergency Plan, January 1996**

The Regional Disaster Medical/Health Coordinator (RDMHC) Interim Emergency Plan describes the policies, structure, roles, responsibilities and general procedures governing Region II's response to major disasters.

10) **Marin County Multi-Hazard Plan, December 1992, Annex D and E**

The Multi-Hazard Plan addresses the jurisdiction's planned response to extraordinary emergency situations associated with natural disasters, technological incidents, and nuclear defense operations. It provides operational concepts relating to the various emergency situations, identifies components of the Local Emergency Management Organization, and describes the overall responsibilities of the organization for protecting life and property and assuring the overall wellbeing of the population. The plan also identifies the sources of outside support that might be provided, through mutual aid and specific statutory authorities, by other jurisdictions, state and federal agencies, and the private sector. Annex D refers to Medical Operations and Annex E refers to Public Health Operations.

11) **Marin County Emergency Medical Response Plan, 1998**

This plan is intended for use by any and all agencies that might respond, primarily or in response to a mutual aid request, to any incident that requires emergency medical resources within Marin County; incorporates the Simple Triage and Rapid Treatment (START) triage system and the Incident Command System (ICS); and includes the following:

a) Defined operational concepts and policies for field operations.
b) A system of incident scene management based on predefined organization and checklists.
c) The notification as appropriate of hospitals, ambulance services, coroner and specific agencies by a designated communication facility.
d) A mechanism by which the Coordinating Hospital directs the allocation of hospital resources and distribution of casualties.
e) Provision for an on-scene Information Officer to disseminate accurate information to the media.
f) Establishment of an off-site public information center.
g) A mechanism for obtaining mutual aid ambulances and maintaining ambulance zone coverage.
h) A method for identifying and tracking casualties.

i) A psychological trauma component available to involved personnel, casualties and their families.

5.0 PLAN REVISION AND UPDATE

5.1 Revision Concept

The Disaster Medical/Health Plan is a "living" document in that it can and should be updated regularly to remain effective and accurate.

5.2 Updates

The need for updated revisions shall be evaluated by the Marin County Disaster Medical Plan Steering Committee (Steering Committee), which meets at least quarterly, and anytime one or more of the following occurs:

1) An exercise of the Plan;
2) A declared disaster resulting in activation of the Medical/Health Branch;
3) A significant change in the Federal, State, Regional, or Operational Medical/Health Plans;
4) A significant reorganization or change in organizations or agencies addressed in this Plan; or,
5) Availability of a related after-action report from another jurisdiction following a disaster.

5.3 Mechanism for Review

Any individual wishing to provide input to the Steering Committee may forward that input to the Marin County Department of Health and Human Services (H&HS), EMS Program.

That concern will be put on the agenda with available supporting information, for consideration by the Steering Committee at their next regularly scheduled meeting.

5.4 Distribution of Plan Updates

The EMS office will distribute updated information to the individuals and agencies listed on the Distribution List (Appendix C) as deemed appropriate by the Steering Committee.

II CONCEPT OF OPERATIONS

6.0 SCOPE

This plan is the Disaster Medical/Health Plan (Plan) and, as such, is applicable to any and all persons who may be utilized to support medical and health activities at the Operational Area level. This Plan addresses management of large-scale events which overwhelm the normal day-to-day response capabilities of local jurisdictions. Examples include earthquakes, hazardous material releases, explosions, and/or dam failures that result in large numbers of casualties. It specifically includes all divisions of the Department of Health and Human Services and integrates activities with those of other Marin County departments.

Activation of the Department Operations Center (DOC) will be considered anytime the Operational Area Emergency Operations Center (EOC) is fully or partially activated or the Operational Area Disaster Medical Health Coordinator (OADMHC) so requests.

Where privately owned or non-county agencies are involved, those agencies have been part of the planning process. They have participated by integrating plan activities into their agency's disaster plan and by entering into written agreements with the County of Marin or Department of Health and Human Services regarding their participation and/or role.

The principle functions of the Department Operations Center (DOC) are:

1) To support medical/health functions and response, assuring the provision of appropriate services to the population.
2) To support the acquisition of resources requested by the RDMHC for deployment within Region II or within other regions of California.

This Plan will be activated when a disaster or other large scale incident has occurred or threatens to occur within or outside the county which requires a response by medical and/or health agencies over and beyond day-to-day operations. Specifics of activation are found in section 18.0.

Examples include multi-casualty incidents (refer to the Emergency Medical Response Plan), full or partial activation of the Operational Area Emergency Operations Center (EOC), activation of the Region II RDMHC plan, or receipt of information expected to lead to any of these.

7.0 GENERAL RESPONSIBILITIES DURING EMERGENCY PHASES

7.1 Preparedness

7.1.1 Definition

This phase is defined as a time of normal day-to-day activities.

7.1.2 Phase Activation

No activation required.

7.1.3 Duties and Responsibilities

During this phase, responsible agencies and personnel will participate in the following activities:

1) Familiarize themselves with pertinent sections of the Emergency Medical Response Plan, the Operational Area Emergency Plan, the Region II RDMHC Emergency Plan and the Standardized Emergency Management System (SEMS).
2) Participate in regularly scheduled exercises of the plan provisions.
3) Participate by attending or providing input to the Disaster Medical/Health Plan Steering Committee.
4) Coordinate with local medical/health facilities to assess their preparedness.
5) Identify medical/health disaster communications needs and assist in creating a system linking response providers, health facilities, Operational Area Emergency Operations Center (EOC) and field operation sites. Develop plans for back-up systems as needed.
6) Promote health care agency/department preparedness through regularly scheduled training and exercises to test emergency response.

7.2 Increased Readiness

7.2.1 Definition

This phase refers to the period of time following receipt of information likely to lead to a higher level of response.

7.2.2 Phase Activation

Phase is activated at the discretion of the OADMHC as defined by the OADMHC.

7.2.3 Duties and Responsibilities

Following assessment of the situation and the information available, the OADMHC shall consider and/or cause the following activities to occur:

1) Alert and brief Health Department Director and Assistant Director.
2) Alert and brief all command staff.
3) Consider staff assignments, notification of additional staff.
4) Schedule periodic re-assessments and notifications.
5) Review related plans, information, etc.
6) Prepare to escalate readiness level.

7.3 Pre-Impact or Medical Advisory Alert

7.3.1 Definition

The phase exists when an incident has occurred or is imminent and is expected to generate a substantial number of casualties and/or significantly increased need for medical/health services.

7.3.2 Phase Activation

This phase is activated by the OADMHC, usually at the request of a field incident commander.

7.3.3 Duties and Responsibilities

1) Assure that appropriate staff has been alerted and activated.
2) Assure that the Director of HHS and Assistant Director have been notified.
3) Assure that appropriate OES and County administrators have been notified.
4) Begin incident logging activities.
5) Assess situation frequently and prepare to escalate status.
6) Assure dissemination to public of appropriate information.
7) Review checklists and assume duties as appropriate.

7.4 Impact/Immediate Response

7.4.1 Definition

This phase exists when an incident has occurred resulting in a large number of injuries. The incident commander on scene has declared a Level III or IV incident. This may be a single incident or part of a wide spread disaster and, by definition, also includes activation of the DOC.

7.4.2 Phase Activation

This phase is activated, to the extent that is appropriate, anytime a Level III or IV emergency medical response is declared, Operational Area EOC is activated or the OADMHC deems that activation would aid in the response to an emergency situation.

7.4.3 Duties and Responsibilities

Specific duties and responsibilities are detailed in Section 13.0, but include the following:

1) Maximize the provision of medical care to the community.
2) Gather and organize information, evaluating the impact of the incident and needed resources.
3) Assure the establishment of reliable communications within and among medical/health providers.
4) Disseminate warnings, public information and instructions to the public.
5) Mobilize and allocate medical/health facilities and systems.
6) Restore or re-activate medical/health facilities and systems.
7) Maintain complete and accurate records of resources utilized.
8) Supervise the evacuation of casualties and facilities as necessary.

7.5 Sustained Response

7.5.1 Definition

This phase follows the "impact/immediate" response period beginning with the first operational period (12 hours).

7.5.2 Phase Activation

Phase activation evolves to follow the "impact/immediate" phase.

7.5.3 Duties and Responsibilities

A continued activation, the health of the affected population is maintained through continued medical/health care and rehabilitative services. Responsible agencies will:

1) Ensure that hospital and nursing home patients continue to receive care, and that persons moved to mass care facilities receive appropriate services.
2) Establish or augment services to deliver medical/health care to the public for non-disaster related health problems.

7.6 Recovery

7.6.1 Definition

This phase follows either the "impact/immediate" response phase or the "sustained" response phase. It begins when demobilization or the movement toward re-establishment of usual day-to-day activities begins.

7.6.2 Phase Activation

This phase is evolutionary and may begin at anytime after impact.

7.6.2 Duties and Responsibilities

Priority during this phase will be given to maintaining essential medical and health services and restoring the disaster area's ability to deliver medical/health care.

8.0 QUALITY ASSURANCE

Participants are expected to perform the following functions during the response, to the best of their abilities, given the resources available and the constraints imposed by the incident:

1) To maintain activity logs that reflect activities during their participation;
2) To maintain records of any costs incurred during the incident;
3) To participate in a debriefing to be scheduled following demobilization of incident activities; and

4) To provide the Steering Committee with written suggestions within 60 days of demobilization for improved response.

9.0 TRAINING, TESTS AND EXERCISES

9.1 Training

The Steering Committee will make reasonable efforts to assure availability to personnel who may be utilized under this Plan of training in the following:

1) Personal Disaster Preparedness
2) Office Building Disaster Plan
3) Emergency Medical Response Plan
4) Multi-Hazard Plan (12/92)
5) Operational Area Emergency Plan
6) Medical/Health Disaster Plan
7) Red Cross Shelter Management and Maintenance
8) Other plans and information as appropriate.

9.2 Tests and Exercises

At a minimum, the OADMHC will organize and cause to be conducted, semi-annual communication exercises, either jointly with other departments and agencies or separately, involving only DOC related activities.

III RESPONSE ORGANIZATIONS - ROLES AND RESPONSIBILITIES

10.0 FEDERAL RESPONSE AGENCIES

Medical assistance from the Federal government can be requested by the state if the demand for medical resources exceeds the capabilities of the lower levels of government.

10.1 Federal Emergency Management Agency (FEMA)

Under the coordination of the Federal Emergency Management Agency (FEMA), federal agencies will provide resources to support state and local emergency response efforts at the request of and in coordination with state response officials. Federal agencies may, under their own authority, provide disaster assistance prior to a presidential declaration.

10.2 Federal Agencies

Federal agencies and organizations with responsibilities for the support of the states' medical response are the United States Public Health Service (USPHS), Department of Veterans Affairs (VA), Department of Defense (DOD), and Department of Transportation (DOT). The Department of Veteran Affairs provides medical supplies and equipment.

The primary response function of the Department of Defense is urban search and rescue. The DOD may also support other medical response functions by providing the following:

1) Casualty transportation;
2) Transportation for material and personnel;
3) Medical supplies; and
4) Other logistic support.

The primary response function of the Department of Transportation (DOT) is to coordinate transportation, route recovery, and establishment of staging areas for the receipt, storage and deployment of disaster supplies and equipment.

10.3 National Disaster Medical System (NDMS)

In 1983, Congress created the National Disaster Medical System (NDMS) to improve the federal government's ability to respond to medical disasters. The NDMS is a joint program of the Public Health Service, Department of Veterans Affairs, Department of Defense, and Federal Emergency Management Agency. Through a coordinated effort, the NDMS:

1) Provides Disaster Medical Assistance Teams (DMATS) to support patient care operations within the disaster area;
2) Assists communities to develop the capability to receive evacuated casualties; and
3) Coordinates the evacuation of casualties to sources of medical care outside the state.

11.0 STATE AGENCIES AND DEPARTMENTS

11.1 Governor's Office of Emergency Services (OES)

The Governor's Office of Emergency Services (OES) is responsible for the overall coordination of the state's disaster response.

OES is responsible for initiating the state response to disasters, including alerting and activating state agencies with response responsibilities. It provides approval for expenditures for acquisition of resources and requests for federal assistance. OES operates the State Operations Center (SOC) in Sacramento.

State OES's response objectives are to:

1) Promote joint priority setting among the responding departments.
2) Monitor the progress of the various response elements in attaining response goals.
3) Collect, interpret and disseminate disaster intelligence.
4) Represent the Governor in the direction of the response.

11.2 Emergency Medical Services Authority (EMSA)

The EMSA coordinates the state's medical response to major disasters. The Director of EMSA is the State Disaster Medical Coordinator (SDMC) and serves as a member of the Governor's Emergency Operations Executive Council.

The EMSA is responsible for:

1) Developing and updating state medical plans and procedures;
2) Providing advice, training, and technical assistance to local agencies in disaster preparedness;
3) Promoting the preparedness of private and public sector medical response resources;
4) Designing, activating and evaluating periodic exercises to test response capabilities;
5) Coordinating with the Public Health Service, NDMS, and other federal agencies with medical response roles;
6) Establishing the EMS Operations Center (EMSOC) and the Unified Medical Operations Center (UMOC) with the California National Guard;
7) Managing the Medical and Health Branch of the State Operations Center (SOC); and
8) Establishing medical response policies and priorities.

11.3 State Department of Health Services (DHS)

The DHS is responsible for the state public health and environmental health response to a disaster. DHS also supports the state medical response by establishing and operating the Joint DHS/EMSA Emergency Operations Center (JEOC). DHS also directs the deployment of resources to protect the public and environmental health, and performs licensing inspections of hospitals, nursing homes, and clinics.

11.4 Office of Statewide Health Planning and Development (OSHPD)

The role of the Office of Statewide Health Planning & Development (OSHPD), in conjunction with the Office of the State Architect (OSA), includes:

1) Inspecting hospitals following earthquakes to ensure their structural integrity.
2) Providing information on hospital status and capabilities to EMSA, OES, and Operational Area Coordinators.
3) Assisting the EMSA in setting priorities for the restoration of hospital services.

11.5 Department of Mental Health and Department of Social Services

The disaster response role of the Department of Mental Health (DMH) includes:

1) Coordinating the State mental health response.

2) Collecting information on the status of state mental health facilities within the affected area.
3) Providing ongoing mental health assistance during the recovery period following a disaster.

The role of the Department of Social Services includes:

1) Assisting with the placement of disaster victims in shelters.
2) Ensuring that victims have access to clothing and food.
3) Providing personnel to establish claims for losses for victims of the disaster during the recovery period.

11.6 Military Department

The U.S. Military has greatly reduced its presence in California. The California National Guard employs its forces for various support missions including:

1) Air and surface transportation.
2) Distribution of food, essential supplies and materials provided by other agencies.
3) Coordination of evacuation of patients from Regional Evacuation Points and Mobilization Points.
4) Limited field medical support

11.7 California Amateur Radio Emergency System (CARES)

CARES provides backup disaster communications to the departments of the Health and Welfare Agency, including the EMSA, Health Services, Mental Health, Social Services, and Office of Statewide Health Planning & Development, via HAM radios. CARES will establish communications between state responders at the Emergency Medical SOC (EMSOC), UMOC, or JEOC and the county medical Emergency Operations Centers (EOC) that have amateur radio capability.

11.8 Radio Amateur Civil Emergency System (RACES)

RACES is a FCC authorized organization governed by the State OES. RACES provides a nationwide system of amateur radio stations and operators organized into autonomous local groups which are sponsored by local, county and state governmental agencies, typically OES or a similar agency. For Marin County, it is the Marin County Sheriff's Office of Emergency Services. As such, they are the only amateur radio

operators authorized by the U.S. Federal government to remain "on the air" during declared periods of national emergency.

12.0 REGIONAL DISASTER MEDICAL/HEALTH COORDINATOR (RDMHC)

12.1 Regional Mutual Aid

The two principal functions of the RDMHC are:

1) To coordinate the acquisition of medical and health mutual aid in response to a request from EMSA, DHS, or State OES in support of a state medical/health response to a major disaster, and
2) To respond to Operational Areas requesting mutual aid assistance for disasters within Region II.

The RDMHC will locate, mobilize, and/or arrange transportation for resources requested, and also may coordinate the receipt of casualties evacuated from the disaster area.

Upon the request of Operational Areas (counties) within the Region and/or the OES Regional Manager, the RDMHC will assume additional regional disaster medical/health related functions, including:

1) Coordinating the regional and intra-regional disaster medical and health mutual aid, through the Operational Area Disaster Medical/Health Coordinators;
2) Providing a forum for the development of regional approaches to disaster medical and health preparedness; and,
3) Providing advice to the OES Regional Manager on disaster medical and health issues.

12.2 Duties of the RDMHC

12.2.1 Pre-Incident Duties of the RDMHC:

1) Coordinate the development of a regional medical/health disaster and mutual aid plan.
2) Develop and maintain a system to identify medical/health resources, transportation assets, and communication resources within the region.
3) Establish liaison with other OES Operational Area Coordinators and the OES Regional Administrator.

4) Coordinate the acquisition of medical/health mutual aid in response to a request from the state.
5) Participate in regional and statewide disaster exercises.

12.2.2 RDMHC Duties During and After a Disaster include:

1) For disasters within Region II, coordinate and manage the allocation of all regional, state, federal and private medical and health support to disaster medical/health care operations within the affected area. If a disaster impacts the RDMHC's own county, the Alternate RDMHC may have to assume these duties.
2) For disasters outside of Region II, coordinate the acquisition of operational area, regional and private medical and health mutual aid in support of a state medical/health response to a major disaster.
3) Evaluate requests from the Operational Areas for medical and health support, and determine appropriate response recommendations.
4) Obtain medical and health personnel and related resources through established mutual aid procedures.
5) Coordinate the mobilization and transportation of medical and health resources with the REOC Logistics Section and with the JEOC and the UMOC, if activated.

12.3 Location of the RDMHC

Coordination with other regional mutual aid coordinators and resource systems is important; these include Law, Fire, Mental Health, Hazardous Materials, Water, Engineers and the Emergency Managers Mutual Aid. In most disasters, these regional mutual aid systems would be located or coordinated through State OES's REOC. The Region II RDMHC is the County Health Officer for Contra Costa County, Dr. William B. Walker.

12.4 Region II RDMHC Staff Positions

Refer to the Regional Area Plan for more information.

13.0 OPERATIONAL AREA DISASTER MEDICAL/HEALTH COORDINATORS

This section is from the Regional Area Plan and details the County role from the Regional perspective.

The focus of the medical coordination effort at the county level is the County Director of Health/County Health Officer. The Operational Area Disaster Medical/Health Coordinator (OADMHC) is the person designated by the Director of Health/County Health Officer to be responsible for developing plans and procedures and for the coordinated response of local medical/health resources. In many counties in California, the coordination role is assigned to the Administrator of the local EMS Agency. The OADMHC shall appoint at least one alternate.

The RDMHC will work with the OADMHC in each county for mutual aid needs and resources, on a 24-hour availability basis. Nearby counties can certainly provide mutual aid for each other, but they should notify the RDMHC in situations where their joint resources may not be adequate, or the full resource needs will not be known immediately.

13.1 Pre-Incident Duties of the OADMHC

Develop and annually update all aspects of the medical/health section of the county's and Operational Area's emergency response plan.

Local response plans should address, among other items:

1) Roles and responsibilities of local response agencies before, during, and after a catastrophic event;
2) Development of contact lists of key health officials within each Operational Area;
3) Reporting and operational relationships among the various local response agencies;
4) Policies for determining how medical/health resources are to be acquired and allocated;
5) Strategies for distributing patients among surviving medical facilities, including the role of non-hospital medical facilities;
6) Procedures for requesting and accepting medical and health mutual aid from neighboring jurisdictions and the state;
7) Methods for gathering and disseminating disaster medical/public health information to local and state response officials;
8) Identify, develop and maintain sources for medical/ health resources, transportation, communications, and logistic support;
9) Establish and maintain liaison, and possibly develop agreements with appropriate American Red Cross chapters, volunteer agencies, professional societies, local EMS agency, hospitals, pre-hospital providers, and any nearby military establishments that could provide assistance;

10) Establish and maintain liaison with other service Operational Area mutual aid coordinators such as law, fire, public works, hazardous materials, mental health, engineers and water agencies.
11) Designate field treatment sites and develop plans and procedures to open, staff, and operate them;
12) Designate mobilization centers and rendezvous points for mutual aid resources. Coordinate this selection with other emergency planners, such as OES, fire, law and hazardous materials; and
13) Assist local jurisdictions to develop plans and procedures to:
    a) Alert resource providers and contact points.
    b) Inventory, stockpile, and distribute resources.
    c) Participate in operational area disaster exercises.
    d) Develop agreements with nearby military establishments that could provide assistance.

13.2 OADMHC Duties During and After a Disaster

The requesting Operational Area is the controlling authority for use of medical/health resources provided in accordance with their request. In any situation wherein such resources are not adequate to fulfill multiple local requests in a timely manner, the OADMHC is responsible for the distribution of available resources.

1) Assess the health effects of disaster related events.
2) Provide disaster related health information to the public information officer to be released to the public.
3) Coordinate resource requests and needs within the operational area, notifying the RDMHC of the situation and resource status, and requesting mutual aid as needed.
4) Evaluate resource availability within the operational area.
5) Activate Field Treatment Sites and establish mobilization centers for mutual aid resources, as needed.
6) Provide preventive health services.
7) Provide food handling, mass feeding, and sanitation service in emergency facilities.
8) Assess and advise on general sanitation matters.
9) Coordinate with hazardous materials personnel to minimize loss of life and adverse physical effects, and reduce environmental damage due to hazardous or toxic materials.
10) Coordinate with other mutual aid systems and EOC sections, such as Mental Health, Public Works, Water, Utilities, Law & Fire to ensure health needs of the public & emergency response workers are being met.

13.3 Roles for County Personnel

13.3.1 Department of H &HS, Administrative Staff (Executive)

Preparedness phase

1) Participate in personal preparedness and plan training.
2) Actively support and encourage plan development, staff education, staff participation.
3) Encourage support staff to train for DOC support positions.

Increased Readiness though Pre-Impact phases

1) Participate in decision making process, accelerated preparedness activities.

Impact/Immediate Response through Recovery phases

1) Participate as requested.
2) Anticipate assignment as:
   a) Medical/Health Officer, Op Area EOC
   b) DOC Director
   c) Operations Section Chief
   d) Finance/Administrative Section Chief and staff
   e) Other Command Roles

13.3.2 Department of H & HS, Division of Health Services

Preparedness phase

1) Participate on Steering Committee.
2) Provide expertise, advice regarding inclusion of client base.
3) Assist to identify community agency planning needs.
4) Assist to identify community agency resources.
5) Facilitate DOC/Community agency formal planning.
6) Encourage community disaster preparedness education.
7) Encourage staff training for disaster roles.

Increased Readiness though Pre-Impact phases

1) Participate in decision making process as requested or assigned.

Impact/Immediate Response through Recovery phases

1) Participate as requested.
2) Anticipate assignment as:
   a) Pre-assigned (most managers will be assigned a role)

b) Any Branch Director
c) Any group leader (may minimize randomness by requesting primary and back-up assignments)
d) Assessment Team Member

13.3.3 Department of H & HS, Division of Social Services

Preparedness phase

1) Participate on Steering Committee.
2) Encourage staff training for disaster roles.
3) Assist to identify community agency planning needs.
4) Assist to identify community agency resources.
5) Facilitate DOC/Community agency formal planning.

Pre-Impact through Sustained Response phases

1) Participate as requested.
2) Anticipate assignment as:
   a) Operational area Care and Shelter Unit
   b) Assessment Team Member
   c) DMSF group leader
   d) FTS group leader
   e) ARC shelter manager
   f) ARC shelter staff

Recovery phase

1) Provide expertise to resolve shelter issues.

13.3.4 Department of H & HS, Division of Aging

Preparedness phase

1) Participate on Steering Committee.
2) Provide expertise, advice regarding inclusion of client base.
3) Assist to identify community agency planning needs.
4) Assist to identify community agency resources.
5) Facilitate DOC/Community agency formal planning.
6) Encourage community disaster preparedness education.
7) Encourage staff training for disaster roles.

Increased Readiness through Sustained Response phases

1) Participate as requested.
2) Anticipate assignment as:

a) Temporary Care Provider Branch Director
b) Other licensed facilities Group Leader
c) Assessment Team Member

Recovery phase

1) Assist community agencies with documentation of disaster related costs.
2) Assist community agencies with identification of resource needs.
3) Assist community to move toward the resumption of "business as usual".

13.3.5 Department of H & HS, Division of Mental Health

Preparedness phase

1) Participate on Steering Committee.
2) Provide expertise, advice regarding inclusion of client base.
3) Assist to identify community agency planning needs.
4) Assist to identify community agency resources.
5) Facilitate DOC/Community agency formal planning.
6) Encourage community disaster preparedness education.
7) Encourage staff training for disaster roles.

Pre-Impact through Sustained Response phases

1) Participate as requested.
2) Anticipate assignment as:
   a) Mental Health Branch Director
   b) Assessment team member
   c) Care-giver role

Recovery phase

1) Provide expertise to community per Medical/Health Disaster Plan.
2) Provide expertise to support disaster workers.

13.3.6 Community Development Agency (CDA), Environmental Health Services (EHS)

Preparedness Phase.

1) Participate on Steering Committee
2) Provide expertise, advice on community agency needs.
3) Facilitate DOC planning.
4) Encourage staff training for disaster roles.

Increased Readiness through Sustained Response phases

1) Participate in efforts to increase community preparedness, education

Impact/Immediate Response through Recovery phases

1) Participate according to CDA department disaster plan
2) Anticipate assignment as:
   a) Assessment team member
   b) Public Health/Environmental Health Branch

14.0 CITY MEDICAL RESPONSE

Although County Directors of Health/County Health Officers are responsible for coordinating the overall local medical response, cities have important response functions. Many cities have pre-hospital emergency service providers who will provide direct lifesaving care to disaster victims. The plans of these pre-hospital providers should be coordinated with those of the county to ensure proper interface with hospital resources, information sharing, and consistent priority setting.

Cities can also provide non-medical support to hospitals, field treatment sites and other medical operations through their fire and law services as well as through public works and general services.

15.0 PRIVATE SECTOR

Many non-government agencies will be involved in a disaster response. These will include national organizations such as the American Red Cross and the Salvation Army as well as multiple other agencies of varying sizes. The involvement of Hospice and Home Health Care agencies, Board and Care facilities, extended care and skilled nursing care facilities, hospitals and many other volunteer groups will be necessary to provide a comprehensive and organized response.

During the Preparedness phase, these agencies should be identified and roles defined. Needs and resources should be anticipated and the planning process designed to incorporate them in the Plan and through MOU or contract agreements.

16.0 HOSPITALS AND OTHER HEALTH FACILITIES

16.1 Hospitals

During the response to a catastrophic disaster, hospitals in an impacted area have two responsibilities:

1) To protect their staff and maintain the medical status of their patients, and
2) If possible, to provide medical care to disaster victims.

These responsibilities, along with Joint Commission for the Accreditation of Health Organizations (JCAHO) guidelines, require hospitals, clinics and other health care agencies to develop response plans consistent with their jurisdictions' overall medical response plans.

Hospital plans should, at a minimum, address the following:

1) Assessing gross damage and loss of function to the facility. This initial assessment should include surveying for fire, obvious structural and non-structural damage, hazardous materials releases, and loss of utilities. This rapid assessment should be followed as soon as possible with a detailed assessment.
2) Communicating hospital capabilities and needs to county officials responsible for coordinating the medical response.
3) Restoring critical water, electrical, sewer, gas and telephone utilities.
4) Obtaining food and water.
5) Augmenting and relieving staff.
6) Acquiring medical supplies and replacing damaged equipment.
7) Discharging patients.
8) Providing medical care to converging casualties.
9) Securing the facility.
10) Maintaining standards for medical records in order to maximize reimbursement for services provided and facilitating patient follow-up for additional medical care.

Hospital plans and procedures should also address the wellbeing of the families of staff members who may have been affected by the disaster, and the long and short-term mental health problems which may arise among the hospital workers.

Hospitals outside the area affected by the disaster also have important roles to play. If the disaster is catastrophic in impact, hospitals in unaffected areas may be asked to assist in the acquisition of medical personnel. Additionally, if hospitals in impacted areas are severely damaged, the state may evacuate casualties to hospitals in areas unaffected by the disaster.

16.2 Other Health Facilities and Health Care Providers

Community clinics, urgent care centers, dialysis clinics, skilled health care facilities, home care, nursing facilities residential care providers, adult day care and other non-hospital facilities provide essential services to a growing segment of California's population. Following a catastrophic disaster, these facilities have several responsibilities:

1) Protection of staff and clients.
2) Provision of medical services to casualties who are injured on site or converge to the facility.
3) Participation, consistent with the mission of the facility, in the ongoing medical and health response.
4) If unable to provide services, referring both disaster victims and regular clients to appropriate alternative sources of service.
5) Rapid restoration of function to provide services to its normal clientele.

In order for facilities to meet their responsibilities, the facility must:

1) Develop and exercise disaster plans for internal and external disasters both separately and simultaneously.
2) Establish communication and coordination links with their OADMHC.
3) Prepare their facilities by performing non-structural hazard mitigation.

17.0 PRE-HOSPITAL AND AMBULANCE SERVICES

As with other response resources, pre-hospital and emergency transportation providers both within and outside the affected area have important response roles. Within the affected area, pre-hospital providers may not be able to stabilize all victims and immediately transport them to the closest appropriate medical facility. The number of victims, damage to roads, facilities and vehicles may cause delays. Dispatch, 911, medical direction and other EMS communications may be damaged or overloaded. As a result, EMS personnel may need to perform alternative response functions such as:

1) Information gathering and reporting;
2) Staffing of Field Treatment Sites (FTS);
3) Using vehicle radios to establish communications links among hospitals, FTS and medical EOCs; and
4) Supporting the evacuation of medical facilities.
5) Fire pre-hospital personnel may be diverted to fire suppression rather than medical care immediately following a disaster. Communities with significant fire EMT response

capability should clarify these priorities and develop plans for the contingency that their pre-hospital personnel will be redirected.

In areas unaffected by the disaster, pre-hospital providers may provide:

1) Personnel and vehicle mutual aid;
2) A Regional Ambulance Coordinator to assist Regional Disaster Medical/Health Coordinators to mobilize vehicles and personnel; and
3) Medical transportation for casualties evacuated from the impacted areas.

Ambulance mutual aid should be provided only in response to official requests and/or through officially established mutual aid plans or automatic aid agreements. Ambulance providers responding without valid authorization may interfere in the response and will not be reimbursed for the services they perform.

IV EMERGENCY ACTION/RESOURCE ACQUISITION

18.0 DOC ACTIVATION AND DEACTIVATION

18.1 Activation

The Department Operations Center (DOC) plan may be activated as follows:

1) Increased Readiness Phase.

   OADMHC receives information, utilizes Medical/Health Branch Director (EOC) checklist, Appendix K.

2) Pre-impact Medical Advisory Alert.

   OADMHC receives information. If not from Marin County Communications Center (ComCtr), verifies information obtained with them, and utilizes Medical/Health Branch Director (EOC) checklist is in Appendix K.

3) Impact/Immediate Response.

   OADMHC receives information and joins operations as appropriate.

18.2 Deactivation

The decision to begin deactivation of the medical/health response will be made by the DOC Command Staff as appropriate, based on their evaluation of the response.

This decision will be reflected in the DOC Action Plan. It is noted that DOC activities may begin and end independent of the Operation Area Emergency Operations Center (EOC) activation and deactivation.

Deactivation information is included on individual position checklists, Appendix K.

19.0 DEPARTMENT OPERATION CENTER (DOC) STRUCTURE

Organizational Statement

In accordance with SEMS regulation, the Department Operations Center is defined and structured to support the Medical/Health Branches of the Operational Area Emergency Operations Center (EOC).

The OADMHC is responsible for activating the Plan at which point the DOC structure is implemented as appropriate and functions assumed and performed within the structure.

The DOC structure is illustrated in the Medical/Health DOC Chart on the chart in Appendix K.

The shaded boxes indicate command staff, the positions that should be included in the decision making process on the chart in Appendix K.

As with all ICS structures, only those positions needed to manage the incident will be filled and the structure expanded or contracted as circumstances change.

Requests for resources may reach the DOC through several channels. Priority for resource allocation will be determined according to the overall response Action Plan. Disaster Form 202 form "Operational Area (county) Medical Mutual Aid Resource Availability Report to State EMSA and DHS", and Form 200 for "Casualty Evacuation and Resource Supplies" should be used and are included in Appendix F.

19.1 Medical Supplies, Equipment and Pharmaceuticals

The following caches of supplies are maintained within Marin County:

Medical Supply Cache System (12):

1) Located at multiple fire stations throughout the county.
2) Maintained by fire departments or districts.
3) Used to support initial medical activities at an incident scene.
4) Can provide supplies to assist with initial care for up to 50 patients
5) Deployed when requested by scene Incident Commander or Medical/Health Branch Director of the EOC.
6) Contents and locations are listed in Appendix E.

Field Treatment Site Caches (3) are:

1) Located at the Marin County Sheriff's maintenance yard at the Civic Center in San Rafael.
2) Two caches are on mobile trailers with one truck to haul them; one cache is stationary. The truck is maintained and driven by DPW personnel upon request to the appropriate DPW authority. Before departure, the driver will need to obtain a generator, gasoline and light stand from the stationary FTS cache container as well as check and secure the contents and doors of the trailer.
3) Maintained by the Sheriff's OES and H&HS-EMS programs.
4) Used to equip field treatment sites (See Appendix E and H).
5) Cares for up to 150 patients for up to 72 hours.
6) Deployed only by the DOC Director as needed.
7) Pharmaceuticals located separately require 4-6 hours to establish.
8) Requires physician and nurse staffing, and a specific predetermined site.
9) Contents are listed in Appendix E

All facilities are encouraged to arrange, as part of their pre-planning activities, for the augmentation of medical and non-medical supplies to the extent possible.

19.2 Personnel

All licensed facilities are expected to address staffing issues in their disaster planning process.

19.2.1 Medical Personnel

Medical personnel employed in Marin County facilities are expected to be available, when possible, to their employers for utilization according to the employer's needs.

Technical medical personnel not normally employed in Marin County or unable to reach their place of employment may be requested to report to a specific location. Those able to produce original licenses or certifications will complete an application and a summary of their work experience. They will become part of a technical medical personnel pool that will be utilized to supplement staffing needs in hospitals, DMSFs, FTSs, and other sites as needed. Those personnel can expect to work 12-hour shifts and to be paid by the County of Marin through the registry providing processing and scheduling services.

19.2.2 Volunteers

The Volunteer Center will develop a personnel pool of volunteers and make them available as needed. Telephone number is (415) 479-5660, at 650 Las Gallinas Avenue, San Rafael, CA.

Medical personnel can be obtained through requests to the RDMHC. Requests must be made in advance of need and after all local resources are explored and utilized. Form 200 for requesting personnel resources is available in Appendix F.

19.2.3 Public Employees

Public employees may be utilized as directed by their superiors. All county employees are available for assignment and their availability should be considered, especially in instances of sustained response. Care should be taken to assure their assignment to duties appropriate to their training and physical condition.

In addition to the categories discussed above, the need for specialty personnel teams should be evaluated. Some of these are as listed below:

1) Public Health Personnel
2) Critical Incident Stress Debriefing Teams (CISD)
3) Environmental Health Personnel
4) Hazardous Materials (HazMat) Response Team or mitigation experts
5) EMS Personnel
6) Others

19.2.4 CISD Teams & HazMat Teams

Disaster Medical Assistance Teams (DMAT) and additional HazMat resources may be requested through the RDMHC if appropriate.

19.3 Hospitals

19.3.1 Concept

One of the earliest priorities following a disaster is the assessment of the condition of various hospitals and the establishment of a plan to support them in

their efforts to care for their current patient populations and to meet increased demands for patient services that may occur.

There are three acute care hospitals in Marin County. Marin General Hospital and Novato Community Hospital are owned and managed by Sutter Health; Kaiser San Rafael is owned and managed by Kaiser Permanente. Marin General Hospital and Kaiser are located in unincorporated areas. Novato Community Hospital is located within the city limits.

A Hospital Group has been created within the Facilities Branch of the DOC to maximize hospital's ability to centralize their assets, resources, and needs requests.

19.3.2 Mission

To coordinate activities of acute care facilities and hospitals related to the incident and to coordinate the interface between facilities and the DOC.

19.3.3 Group Membership

The Hospital Group shall be composed of representatives from the following facilities:

1) Kaiser Hospital (Kaiser Permanente), San Rafael
2) Marin General Hospital (Sutter Health), Greenbrae
3) Novato Community Hospital (Sutter Health), Novato

19.3.4 Group Tasks

Pre-event Activities

1) Identify designated representatives.
2) Establish regular meeting schedule.
3) Evaluate potential activities, formulate action plans, and methods of interaction to be used following the disaster.
4) Collaborate with Steering Committee to write Plan.
5) Assure training of personnel to plan activities.
6) Exercise Plan.
7) Suggest appropriate modification for incorporation into the Operational Area Emergency Plan (EOP).

19.3.5 Event Activities

1) Provide facility information to Operational Area EOC on "Form A" in Appendix F
2) Establish Operational Area EOC contact schedule, mechanisms, etc.
3) Update, per agreed schedule, facility information on "Form B" in Appendix F and estimate need for resources.
4) Establish Hospital Group within 4-12 hours, as able, utilize liaison officers, and establish Medical/Health DOC contact.

If requested to do so by the OADMHC, the RDMHC with the cooperation of the County Health Officers and emergency medical services systems may request hospitals in unaffected areas of the state to:

1) Determine the number of evacuated casualties they can provide for and communicate this information to the OADMHC; and
2) Serve as a clearinghouse for staff interested in volunteering to provide medical care in the disaster area or at casualty reception areas within the region.

At the request of the OADMHC and in coordination with the County Health Officer and emergency medical services system for the jurisdiction, hospitals in the affected area will activate their disaster plans.

19.4 Disaster Medical Services Facilities (DMSF)

19.4.1 Definition

DMSFs are facilities that, during the normal course of events, provide medical or medically related services. When utilized as DMSFs, these facilities, with assistance, will provide their normal range of services to an expanded client base. To meet the need for additional medical services, this plan has identified and defined, by contract, Disaster Medical Services Facilities (DMSFS). Refer to Facilities Branch, DMSF Group, Appendix G.

19.4.2 Mission

To provide care and shelter for clients defined as Category II or III (refer to Shelter Guidelines) as requested during a declared disaster and/or to provide primary medical services.

19.4.3 Mechanism for Activation of a DMSF

A DMSF may be activated by the Operations Section Chief of the DOC following identification and evaluation of the need for same and consultation with the Services Branch, Care and Shelter Unit of the Logistics Section of the Operational Area EOC.

19.4.4 Procedure for Activation of a DMSF

1) Confirm need for activation with Operational Area EOC.
2) Confirm availability of an appropriate DMSF, most are condition-specific, if not previously established.
3) Verify DMSF needs, i.e., staff, equipment, supplies, etc.
4) Arrange transportation of clients from location to DMSF as mutually agreed upon.
5) Use of DMSF and control of client movement in or out of DMSF resides with the DMSF Group, Facilities Branch, Operations Section, Medical/Health DOC.
6) DMSF designation, depending on its patient care capability, may not be publicized during incident.

19.4.5 DMSF Facilities

An information page for each contracted DMSF facility is found in Appendix G.

19.5 Field Treatment Sites (FTS)

19.5.1 Concept

It may be necessary, in the event of a widespread disaster, to arrange for the provision of basic medical services outside of, or in addition to, acute care hospital facilities. FTSs will be located where needed and not necessarily near a hospital. To meet the need for additional medical services, this plan has identified and defined, by contract, Field Treatment Sites (FTSs). Refer to Facilities Branch, FTS Group, Appendix H.

19.5.2 Definition

FTSs are locations that, during the normal course of events, do not provide medical or medically related services. These facilities, when utilized as FTSs, will require that the County provide staff, supplies, and equipment as needed. An example would be the use of a school site to provide medical care.

19.5.3 Mission

To provide medical care for clients as requested during a declared disaster.

19.5.4 Mechanism for Activation of an FTS

A FTS may be activated by the Operations Section Chief of the DOC on the recommendation of the Hospital Group, following identification and evaluation of the need for same and consultation with the Services Branch and the Care and Shelter Unit of the Logistics Section of the Operational Area EOC.

19.5.5 Procedure for Activation of a FTS

1) Confirm need for activation and evaluate alternatives.
2) Confirm availability of appropriate FTS if not previously established.
3) Establish Field Treatment Site Group if not previously done.
4) Verify time frame for establishment of FTS and assembly of needed supplies, equipment, staffing. Estimate minimum of 6 hours to establish functional FTS.
5) Responsibility for establishment of FTS and duration of use resides with FTS Group, Temporary Care Branch, Operations Section, Medical/Health DOC.

19.5.6 FTS Facilities

An information page for contracted FTS facilities is found in Appendix H.

19.6 Shelter Guidelines

19.6.1 Concept

The American Red Cross (ARC), having designated sites and trained personnel available, will activate and maintain shelter sites as needed, limited only by resources and circumstances. They will, at a minimum, provide space, food, blankets, cots, and first aid services.

It is clear that there are likely to be special needs populations requiring services and accommodations over and above the needs of the general population. To provide shelter and appropriate services for those individuals, this plan has identified special populations, adopted the definitions of Special Needs Shelters found in the Disaster Manual for Public Health Nursing in California, and defined and established Disaster Medical Services Facilities (DMSFs) and Field Treatment Sites (FTSs).

19.6.2 Special Populations Identified

Special populations that were identified as potentially requiring accommodation are as follows:

1) The elderly
2) Non-English speaking persons
3) The physically disabled
4) Preschool and other school populations
5) The medically fragile, including dialysis dependent individuals
6) Those living in group homes, both licensed and smaller
7) Drug dependent (medically prescribed or otherwise)
8) Developmentally disabled
9) Mental health population

19.6.3 Definitions

Special Needs Shelters are defined according to four categories as follows:

1) Category I - individuals requiring shelter which includes recurring professional medical care, special medical equipment and/or continual medical surveillance. Examples of patients in this category include, but are not limited to, the following:

    a) Severe respiratory cases (oxygen dependent)
    b) Dialysis patients
    c) Comatose patients
    d) Immobile paralyzed persons to include muscular dystrophy persons
    e) Severe mentally disturbed persons (potentially violent)
    f) Bed confined persons
    g) Persons requiring intravenous feeding or medications
    h) Persons with severe developmental delay

i) End stages of Alzheimer

2) Category II - individuals requiring shelter and some medical surveillance and/or special assistance. Examples of patients in this category include, but are not limited to, the following:

a) Severely reduced mobility persons
b) Moderately mentally ill persons (non-violent)
c) Persons with significant developmental delay
d) Infants on Apnea monitors and persons with other technologically dependent conditions requiring assistance.

3) Category III - individuals requiring shelter who are independent in the pre-shelter state, but may require limited special assistance or surveillance due to pre-existing health problems. Examples of patients in this category include, but are not limited to, the following:

a) Epilepsy
b) Mild to moderate muscular dystrophy
c) Diabetics on insulin
d) Heart patients with pacemakers
e) Heart patients with implanted defibrillator
f) Hemophiliacs
g) Persons with artificial limbs
h) Extremely poor vision (uncorrected)
i) Extremely poor hearing (uncorrected)
j) Persons in a non-walking cast
k) Severe asthmatics
l) Special diet persons
m) Severe speech impediment

4) Category IV-individuals requiring shelter and are capable of providing for themselves.

These categories are neither inclusive nor exclusive but should serve as guidelines by which the appropriateness of shelter can be determined.

19.6.4 Special Population Sheltering

This plan for sheltering special populations would be utilized when special populations, not able to be accommodated by usual ARC shelters, are identified as needing services.

Shelter activation will occur to provide the most appropriate services for the population requiring assistance. If there is a period of time between the time that special population needs are identified and the time they can be accommodated in a DMSF or FTS, attempts will be made to place them in a standard shelter and to augment services at that location until the individual can be relocated or the shelter re-designated.

Category I patients will be transferred to like facilities if they are moved from an inpatient care setting. If not hospitalized at the time of the disaster, attempts will be made to place patients meeting Category I criteria with an in-patient facility.

Category II patients require medical assistance. Pre-existing caregivers and necessary equipment and supplies should accompany these individuals when they are moved. There must be a registered nurse present in any shelter area accommodating Category II patients.

Category III patients should be accompanied by any necessary equipment and supplies but do not require a specified level of medical assistance.

Category IV patients require no special accommodations.

19.6.5 Designations

The list of facilities designated as DMSF is found in Appendix G and as FTS in Appendix H. Facilities will be added as a contract or memorandum of understanding is completed. Included with the listing is an information page for each facility that will specify contact persons, address and map location, areas of the facility that may be utilized, services that will be provided, and assistance that will be necessary for activation.

19.7 Assessment Teams

19.7.1 Concept

Immediately following the occurrence of a disaster, multiple agencies have a definitive need to assess the impact of the incident and to evaluate and provide for the needs of the population affected. This need results in "windshield" surveys being done piecemeal fashion by multiple agencies. "Windshield"

surveys are initial assessment surveys that are quick visual assessments done while driving through affected areas.

It is suggested that this information should be obtained by predefined teams through a coordinated effort with affected agencies who will perform a predetermined survey of impacted areas of the county in an organized manner. This method will yield a more complete survey with less vehicular traffic in a manner that provides safety, access to affected areas, security for the assessment team and communications with the command post.

It is also suggested that secondary assessment teams visit all established shelters and/or care sites on a regular basis until recovery is complete, i.e., initially once/day.

19.7.2 Purpose

The purpose of the initial team assessment will be as follows:

1) To gather damage information and
2) To disseminate generic information to the public.

The purpose of the secondary assessment teams will be as follows:

1) To gather information;
2) To disseminate generic information;
3) To provide quick initial assessments of individual and group needs;
4) To request additional resources from the operational area EOC/DOC; and
5) To make face-to-face contact with all established care and/or shelter sites.

19.7.3 Team Membership

While it is assumed that the assessment teams may need to include members from multiple agencies, it is urged that the teams be used to collect the most information with the least number of persons through a coordinated effort with affected agencies.

The membership suggested below is determined by the type of personnel expected to be needed to complete assessments that will facilitate the work of the medical, health, and environmental health personnel.

Suggested membership is as follows:

1) Law enforcement person (to assure team safety and access)
2) Public Health nurse
3) Environmental Health person
4) Mental Health practitioner (secondary assessment team)
5) Red Cross Damage Assessment person (initial assessment team) or Shelter or Family Service person (secondary assessment team)
6) Building Inspector - Building inspector is included in this group for the purpose of advising medical/health personnel and the public of general safety issues related to structures, not for the purpose of doing dollar damage assessments
7) A person familiar with the area being surveyed (if above personnel cannot provide this expertise)

19.7.4 Team Requirements

The following items are required for team support:

1) Vehicle with four-wheel drive capabilities or a substantial vehicle for potential rough terrain.
2) Ability to communicate between vehicle and EOC or DOC.
3) Equipment as appropriate to support brief intervention by team members (e.g., first aid supplies, plastic bags, building tags, "caution" or "keep out" tape, vehicle and individual ID, etc.).
4) Predetermined route maps with current updated information.

19.7.5 Additional Considerations

1) It is estimated that at least four teams would initially be needed to accomplish coverage of the county in a reasonable amount of time.
2) If multiple vehicles are necessary to accommodate the agencies needing information, vehicles should travel in caravan and have vehicle-to-vehicle communication capabilities.
3) Team assignment areas should be defined prior to the incident (during planning) with maps detailing areas or buildings of special interest (hospitals, extended care facilities, areas of expected difficulty, etc.).

4) Following initial assessment, the number of teams, composition of the teams, purpose of the assessments, and territory covered would be adjusted as needed by the appropriate unit or branch supervisor based on information available at the time.

Equipment lists are in Appendix L and duty checklists for the Assessment Team Manager is included in Appendix L.

19.8 Mutual Aid

Affected jurisdictions may request mutual aid from neighboring jurisdictions. Consideration must be given to the likely region wide impact of catastrophic disaster making assistance unavailable at the usual expected levels. Pre-event mutual aid agreements and joint planning will expedite the response of available aid and make it more likely.

19.8.1 Local Government Mutual Aid

Requesting medical/health aid from outside the county requires that the request be done in one of two ways:

1) The channels for the mutual aid are pre-established in a written agreement and the responding agencies do not negatively impact the provision of care in their home jurisdiction. A direct request to the agency may be made.

2) The request for aid is made to the RDMHC who coordinates the provision of that aid on a region-wide basis.

It is vital that the movement of resources in and out of any Operational Area be tracked to avoid under or over estimation of resources requested and used and to maximize reimbursement potential. If requests are made from agency to agency, both the need and the fact that the need has been met should be communicated to the DOC.

19.8.2 Fire Service

The fire services mutual aid system also has access to medical resources through the pre-hospital fire responders employed in many jurisdictions. To reduce the probability of duplicate requests, the DOC Operations must

coordinate closely with the Fire Suppression Group of the Operational Area EOC Operations Section.

19.9 Cost Reimbursement

Reimbursement for medical response costs incurred during the incident will depend on the resource and the manner in which it was obtained.

The requesting jurisdiction is responsible for the costs incurred for mutual aid services, supplies and/or resources that it specifically requests, subject to any mutual aid agreements that exist at the time of the request.

To maximize opportunities for federal and state cost sharing for the purchasing of medical resources or services, only costs incurred through authorized channels are available for reimbursement and must be closely and accurately tracked.

Worksheets, logs and expense tracking suggestions are found in Appendix F.

19.10 Transportation and Other Support

The Operational Area EOC Logistics Section coordinates transportation for supplies, equipment, and personnel as well as the provision of non-medical supplies.

Ambulance transport is considered a medical resource and is managed by the DOC. Non-medical transport of individuals, such as using a bus to take persons from an evacuated area to a shelter, would be handled by the Operational Area EOC Logistics Section, and some transport, such as using a bus to move patients from home care to a shelter, could be a jointly coordinated effort.

Agencies are encouraged to seek non-medical support from their city EOC first, if available, contacting the Operational Area EOC when the need cannot be filled at that level.

19.11 Evacuation

19.11.1 General Evacuation

Evacuation is the removal of individuals from an area and may occur on many different levels for different reasons, impacting medical/health activities in a variety of ways.

Law and fire personnel usually coordinate the evacuation of individuals from a threatened area. Assistance from the DOC may be necessary to support individuals requiring medical assistance.

Evacuation of medical facilities, while coordinated by law and fire, may require substantially more medical/health resources as well as the assistance of the DOC in finding appropriate secondary placement. The need for this type of evacuation should be carefully weighed with all alternatives considered.

Evacuation of individuals with medical needs into another jurisdiction must be coordinated by the DOC with the region and with appropriate individuals in the receiving jurisdictions. At a minimum, facilities with agreements in place should notify the DOC of their intent to transfer out of jurisdiction prior to beginning transfer to allow maximum utilization of multi-jurisdictional resources.

The OADMHC may request the state to assist with evacuation to unaffected areas of the state or nation.

Large-scale evacuation of casualties from the county is not addressed in this plan. Please refer to the Regional and State Disaster Medical Plans.

19.11.2 Types of Evacuation

1) *Spontaneous Evacuation.* Residents or citizens in the threatened areas observe an emergency event or receive unofficial word of an actual or perceived threat and, without receiving instructions to do so, elect to evacuate the area. Their movement, means, and direction of travel is unorganized and unsupervised.

2) *Voluntary Evacuation.* This is a warning to persons within a designated area that a threat to life and/or property exists or is likely to exist in the immediate future. Individuals issued this type of warning or order are NOT required to evacuate, however, it would be to their advantage to do so.

3) *Mandatory or Directed Evacuation.* This is a warning to persons within the designated area that an imminent threat to life and/or property exists and individuals MUST evacuate in accordance with the instructions of local officials.

20.0 COMMUNICATION

20.1 Call Back

When indicated, the Marin County Sheriff's Department Communications Center (ComCtr) will contact, with callback acknowledgment, the OADMHC.

If notification of Increased Readiness or Medical Advisory Alert status is desired or activation of the DOC is indicated, the OADMHC will contact or assure contact, with callback acknowledgment, of the following:

1) Director or Assistant Director of H&HS
2) OES
3) County Administrator
4) Command and General Staff of the DOC

If additional staff are needed, each contacted member of the command staff will contact and activate staff.

Program staff will provide an updated contact list of employees, including any special skills, to the DOC Logistics Section for use as needed.

Staff Scheduling

If the DOC Action Plan anticipates a sustained response, shifts of not more than 12 hours per 24-hour period will be established and staffing schedules established by the DOC, command and general staffs.

20.2 Department Operations Center

A telephone number will be established and published to provide county medical/health employees with current information about DOC activities, including scheduling. Personnel staffing the DOC for personal use may also use this line.

Telephone and facsimile numbers are located in Appendix J.

Computers are located in the DOC. As long as telephone lines and electricity are available, computers can be used for telecommunications, documentation, spreadsheets, databases, etc.

20.3 Within The County

As appropriate to their assignments, DOC personnel will contact and establish a contact schedule with agencies. Contact shall be made by telephone, facsimile, radio if facility has pre-assigned capability, or RACES if facility has pre-assigned capability or by personal contact.

A facility that cannot be reached shall have a personal contact made as soon as feasible. DOC may request, through the ComCtr that contact by radio be made, or request that law enforcement or fire personnel make personal contact.

20.4 Auxiliary Communications Service (ACS)

ACS is a communications reserve for the State of California. It includes CARES, (California Amateur Radio Emergency Service), RACES (Radio Amateur Civil Emergency Services), Civil Air Patrol (CAP), Military Affiliate Radio System (MARS), Special Emergency Radio Service, and others. ACS also coordinates mutual aid RACES.

CARES provides backup disaster communications to many departments at the State level via amateur radio. It will establish communications between state responders and the medical DOCs that have amateur radio capability. It has established radio stations in Sacramento, Berkeley, Fairfield and Los Angeles.

RACES provides a nationwide system of amateur radio stations and operators organized into autonomous local groups which are sponsored by local, county and state governmental agencies, typically, an office of emergency services agency or similar agency.

It is the Marin County Sheriff's Office of Emergency Services. As such, they are the only amateur radio operators authorized by the U.S. Federal government to remain "on the air" during declared periods of national emergency. For Marin County, RACES communications has been designated for each hospital and clinic. RACES is also placed in strategic locations throughout Marin County to assist with EOC communications.

20.5 Operational Area Satellite Information System (OASIS)

The OASIS is a satellite based communications system with a high frequency radio backup. OASIS provides the capability to rapidly transfer a wide variety of information

reports between OASIS user agencies. OASIS is both a communications network and information dissemination system.

The intent of OASIS is to provide disaster resistant communications between Operational Areas, state OES Regions, OES Headquarters, and mobile state telecommunications units.

20.6 Regional Information Management System (RIMS)

RIMS is the follow up to the OASIS project and will use the OASIS data communications capability to reduce resource request backlogs and misdirection of resources.

RIMS is an integral part of the OES information management strategic plan currently being developed. Disaster status and response information, as well as requests, flow from the Operational Area EOCs to the REOCs and then to the SOC.

The SOC summarizes regional status and response information and generates reports for the REOCs; state, federal and local agencies; the governor; the legislature; and the public. The SOC also processes resource requests if possible or forwards the request to the appropriate federal agency.

Requests for medical resources may be transmitted to the Region using RIMS. The form for use is in Appendix F.

The form should be routed through the Operational Area EOC Medical/Health Branch position to the Operational Area Planning Section for entry into the system.

APPENDICES

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APPENDIX A - DEFINITIONS AND ACRONYMS

DEFINITIONS

(Medical Plan):	A plan for providing emergency medical treatment for incident personnel.
(SEMS Levels):	The five levels of response are field response, usually incident scene activities; local government, usually city governments; operational areas, usually referring to the counties; regional areas, usually the same as OES areas; and the state.
(Site Safety Plan):	A legal document required by OSHA before entry into a site and is prepared by the Safety Officer.
(Steering Committee)	Marin County Disaster Medical Plan Steering Committee

ACRONYMS

(ACS)	Auxiliary Communications Service
(ARC)	American Red Cross
(CAP)	Civil Air Patrol
(CARES)	California Amateur Radio Emergency System
(CDA)	Community Development Agency
(CHO)	County Health Officer
(CISD)	Critical Incident Stress Debriefing
(CNG)	California National Guard
(ComCtr)	Marin County Sheriff's Department Communications Center
(DHS)	State Department of Health Services
(DMAT)	Disaster Medical Assistance Teams
(DMH)	Department of Mental Health
(DMSF)	Disaster Medical Services Facilities
(DOC)	Department Operations Center
(DOD)	Department of Defense
(DOT)	Department of Transportation
(EHS)	Environmental Health Service
(EMS)	Emergency Medical Services
(EMSA)	Emergency Medical Services Authority
(EMSOC)	EMS Operations Center (State Level)
(EOC)	Operational Area Emergency Operations Center
(FEMA)	Federal Emergency Management Agency
(FIRESCOPE)	Fire fighting Resources of California Organized for Potential Emergencies
(FTS)	Field Treatment Sites
(H&HS)	Marin County Department of Health and Human Services
(HazMat)	Hazardous Materials

(ICS)	Incident Command System
(JCAHO)	Joint Commission for the Accreditation of Health Organizations
(JEOC)	Joint Emergency Operations Center
(LHO)	Local Health Officer
(MAC)	Multi-Agency Coordination
(MARS)	Military Affiliate Radio System
(MCOE)	Marin County Office of Education
(MCOES)	Marin County Sheriff's Office of Emergency Services
(MED BDE)	175th Medical Brigade
(NDMS)	National Disaster Medical System
(OADMHC)	Operational Area Disaster Medical Health Coordinator
(OASIS)	Operational Area Satellite Information System
(OES)	Governor's Office of Emergency Services
(OSA)	Office of the State Architect
(OSHPD)	Office of Statewide Health Planning and Development
(PHS)	Public Health Service
(Plan)	Marin County Medical/Health Disaster Medical Preparedness Plan
(RACES)	Radio Amateur Civil Emergency Services
(REOC)	Regional Emergency Operations Center
(RDMHC)	Regional Disaster Medical/Health Coordinator
(RIMS)	Regional Information Management System
(SDMC)	State Disaster Medical Coordinator
(SEMS)	Standardized Emergency Management System
(SOC)	State Operations Center
(START)	Simple Triage and Rapid Treatment
(UMOC)	Unified Medical Operations Center
(USPHS)	United States Public Health Service
(VA)	Department of Veterans Affairs

APPENDIX B - REFERENCES

REFERENCES

1. Casualty Collection Point Manual, Alameda County, September 24, 1994.
2. Department of Public Health Emergency Response Plan (San Francisco), November 1995.
3. Hospital Emergency Incident Command System Manual, 2nd Edition, May 1993.
4. Marin County Operational Area RACES Handbook, January 1, 1997.
5. Public Health Nursing Disaster Manual, May 1996.
6. Regional Disaster Medical/Health Coordinator Interim Plan, January 1996.
7. San Mateo County Disaster Medical/Health Plan, 1997.
8. Santa Cruz County Health Services Agency Disaster Medical Services Facilities (DMSF), June 1995.
9. State of California Office of Civil Defense, March 1953.

APPENDIX C - DISTRIBUTION

DISTRIBUTION

1.	Emergency Medical Services Authority	1	
2.	RDMHC, Region II		1
3.	Marin County OES		1
4.	Community Development Agency – Environmental Health		1
5.	Health and Human Services		
	a. Director of the Marin County Health and Human Services	1	
	b. Director of Health Services	1	
	Emergency Medical Services		1
	Chief Nursing Services		1
	Deputy Director CHDP		1
	Chief Children Services		1
	County Health Officer		1
	c. Director of Mental Health		1
	d. Director of Social Services	1	
	e. Director of Aging		1
	f. Personnel analyst		1
	g. C F O		1
6.	Hospitals		
	a. Marin General Hospital		1
	b. Kaiser Permanente Hospital	1	
	c. Novato Community Hospital	1	
7.	Contracted DMSF		1 each
8.	MIDC – Marin Interagency Disaster Coalition	1	
9.	American Red Cross, Marin County		1
10.	Home Health Care and Hospice Agency		1 each

APPENDIX D - MAP OF REGION II MUTUAL AID REGIONS

APPENDIX E - SUPPLIES

1. Medical Cache Supplies and Location – (Fire Departments)
2. FTS Supply List
   a) Perishable Supply List (3 Caches @ separate locations)
   b) Non-perishable Supply List with IV fluids (3 Caches, see below)
3. FTS Supply Locations and How to Obtain Supplies
   a) Caches are located off site from the Civic Center.
   b) Trailers TR1, TR2 and C3 are located in the DPW Corporation Yard, Civic Center-San Rafael. TR1 and TR2 are mobile and C3 is stationary.
   c) To activate Caches and/or Trailers, contact EMS Program Administrator. 415-499-6871.

APPENDIX F - DISASTER FORMS

DISASTER FORMS:

- ❑ Hospital Status (Initial) Form A
- ❑ Hospital Status (Secondary) Form B
- ❑ Governor's OES (RIMS) Mission/Request Tasking Form
- ❑ California SEMS Situation Report
- ❑ California SEMS Medical/Health Branch Status Report
- ❑ Governor's OES Medical/Health Branch Resource Availability Report
- ❑ ICS Forms for Action Plan,
  - ❑ Incident Brief (ICS 201-4 pages)
  - ❑ Incident Objectives (ICS 202-1 page)
  - ❑ Organization Assignment (ICS 203-1 page)
  - ❑ Medical Plan (ICS 206-1 page)
  - ❑ Incident Organization Chart (ICS 207-1 page)
  - ❑ Unit Log (Activity)(ICS 214-2 pages)
- ❑ Marin County Action Plan Forms
- ❑ Worksheets, Logs and Expense Tracking Forms

APPENDIX G - DISASTER MEDICAL SERVICE FACILITY (DMSF)

DMSF

- ❑ List of Contracted Agencies with Specifications
  - ❑ Cedars of Marin
  - ❑ Ross Hospital
- ❑ Contact Information
- ❑ Contracted Agencies and Information

APPENDIX H - FIELD TREATMENT SITES (FTS)

- ❑ Locations
  - ❑ Tamalpais High School, Mill Valley
  - ❑ Sir Francis Drake High School, San Anselmo
  - ❑ San Rafael High School, San Rafael
- ❑ FTS Forms
  - ❑ Patient Treatment Record (PTR)
  - ❑ PTR Supplemental
  - ❑ PTR Log
  - ❑ PTR Summary
  - ❑ Field Medical Station Discharge and Follow Up Directions
  - ❑ Instrucciones Para Estacion Medica
- ❑ Contact Information

APPENDIX I - PIO/PUBLIC INFORMATION SHEETS

APPENDIX J - CONTACT INFORMATION

APPENDIX K - POSITION CHECKLISTS

APPENDIX L - ASSESSMENT TEAM INFORMATION